Sexual Assault Examination Program

Reimbursement Form

Crime Victims Compensation Program

VICTIM INFORMATION

Victim's Name: _____ SSN: _____ - _____ - _____

Victim's Address: _____ City: _____ State: _____ Zip: _____

Victim's Date of Birth: _____ Telephone Number: ( ) _____

Legal Guardian (if victim is a minor): _____

Address (if different from victim): _____

Insurance Company: _____ Policy Number: _____

I authorize the facility listed below to bill my private insurance or any other source of benefit available to me for the examination. I further authorize my billing information and medical records relating to this examination to be released to the Crime Victims Compensation Program for payment consideration and to the prosecutor's office for the purposes of securing restitution.

_____ _____

Victim's Signature (Legal Guardian, if victim is a minor) Date

LAW ENFORCEMENT AGENCY INFORMATION

Law Enforcement Agency: _____ Report Number: _____

Authorizing Law Enforcement Officer: _____ Telephone Number: ( ) _____

Crime Type: □ Adult Sexual Assault □ Adult Rape □ Minor Sexual Abuse

AUTHORIZATION:

Reimbursement can be made only if the examination was authorized by a law enforcement official. Please include the law enforcement report number. The law enforcement officer must sign this form. If the officer is not available, non-commissioned law enforcement personnel or the medical provider may certify that the examination was authorized by law enforcement.

I hereby certify that the above-named victim was authorized by law enforcement to receive a sexual assault forensic examination, which was performed by the provider listed below.

□ Law Enforcement Officer

□ Non-Commissioned Law Enforcement Personnel

□ Medical Personnel

□ Other: _____

_____

Name of Certifying Personnel

_____ _____

Signature Date

MEDICAL FACILITY INFORMATION

Name of Medical Facility: _____ Date of Service: _____

Address of Medical Facility: _____ City: _____ State: _____ Zip: _____

Contact Person: _____ Telephone Number: ( ) _____

A copy of the itemized billing, insurance explanation of benefits (EOB), medical records, and the reimbursement form, must be submitted within one year of the examination. All other payment sources available to the victim must make payment prior to the program making payment on behalf of the victim. Submit to:

Crime Victims Compensation Program
P. O. Box 83720
Boise, Idaho 83720
(208) 334-6080 or (800) 950-2110

Crime Victims Compensation Program

Sexual Assault Examination Program
Reimbursement Form
Instructions

Please refer to the following instructions to assist you in completing the sexual assault examination reimbursement form. Please note that this form is requesting payment for the forensic examination only. If the patient wishes to request financial assistance for the cost of crime related treatment, they must submit a standard Crime Victims Compensation Application for eligibility review.

VICTIM INFORMATION

Victim Name: Name of the patient receiving the examination.

Social Security Number: fill In the Social Security number of the victim (if available).

Victim Address: The mailing address of the victim.

Victim Date of Birth: Fill in the telephone number of the victim, or the legal guardian if the victim is a minor.

Legal Guardian: The name of the legal guardian of the patient, if the victim is a minor.

Address: The mailing address of the legal guardian if it is different from that of the victim.

Insurance Company: The name of any third party payment source that may be available to the victim, i.e. Blue Shield, Medicaid, Medicare or Indian Health Services.

Policy Number: The number of the insurance policy or any other identifying moniker associated with the victim's third party payment source.

AUTHORIZATION TO RELEASE INFORMATION

Signature of the Victim: The signature of the victim authorizing the medical provider to release copies of the bill for service, medical records and insurance information to the program.

Date: The date upon which the authorization to release information was signed by the victim.

LAW ENFORCEMENT AGENCY INFORMATION

Law Enforcement Agency: Name of the law enforcement agency who is authorizing the examination.

Report Number: The law enforcement incident report number assigned to the criminal investigation.

Authorizing Law Enforcement Officer: Name of the law enforcement officer who authorized the examination to be completed.

Telephone Number: The business number to reach the law enforcement officer.

Crime Type: Check the box that best describes the alleged crime.

AUTHORIZATION FOR EXAMINATION

Name of Certifying Personnel: The printed name of the law enforcement officer who authorized the examination. If the officer is not available, non-commissioned personnel of the law enforcement agency (i.e. Victim/Witness Coordinator, Public Information Officer), or the physician performing the examination may certify that the examination was authorized by law enforcement. Please indicate the authorizing persons affiliation by checking the appropriate description.

Signature: The signature of the certifying personnel.

Date: The date upon which the certification of authorization was signed.

MEDICAL FACILITY INFORMATION

Name of Medical Facility: Name of the medical treatment facility where the examination was conducted.

Date of Service: The date that the sexual assault examination was performed.

Address of Medical Facility: The mailing address of the medical facility that conducted the examination.

Contact person: the name of the person to contact at the medical facility regarding billing questions or missing documentation.

Telephone Number: The telephone number of the contact person.